RELEASE OF INFORMATION AUTHORIZATION

I, the Patient, parent, guardian or personal representative of Patient (**name:**) ____________________________________,

Patient's **date of birth** is ______________________, authorize Well Care Services to disclose to and/or obtain from:

____ the following information:

By *initialing* the lines below, I signify that I consent for the following type(s) of information to be released to the above individual/entity:

____Drug/Alcohol Abuse ____Psychiatric conditions ____HIV or AIDs related information ____Medical conditions

DO NOT release the following:____

Treatment Dates:____

Description of Information to be disclosed
(Patient/Patient should ***initial*** each item to be disclosed.)

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Testing Information
____ Educational Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Progress in Treatment
____ Other _________________________

Purpose for which information is to be used:

____Coordinate Treatment ____Assessment/Treatment Planning ____School ____Disability Benefits

____ Legal ____Personal ____Employment conditions ____Other:____

If for legal purposes, give specific reason(must be completed):____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to _Alexis Lyon-Claus, Clinic Administrator_ at the address below. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires **one year from date of signature**, or as otherwise indicated below:

____

Conditions
I further understand that Well Care Behavioral and Medical Clinic will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

Inability to coordinate treatment or share any information related to your care with any of your other service providers.

____

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically

Re-disclosure
Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

____

____

I will be given a copy of this authorization for my records.

____
Signature of Patient   Date

____
Signature of Parent, Guardian or Personal Representative   Date

____
Description of Parent, Guardian or Personal Representative Authority

If you are signing as a personal representative of an individual, please describe your authority to act for this individual.

____

____

____

______ **Check here if Patient refuses to sign authorization.**

____
Signature of Well Care Services Witness   Date